NC MEDICAID
OUTPATIENT TREATMENT REPORT
(for Area Programs and Providers Contracted with Area Programs)

Mail To: ValueOptions, Inc
P.O Box 13907
RTP, NC 27709

PATIENT DEMOGRAPHICS

Patient's Name _____ Date of Birth ___/___/___
Age ___ Gender ___ Patient SS #_____

Patient Medicaid # _____-____-_____

(if pending date applied for _____)

Parent/Guardian Name _____

Patient/Guardian(Parent) Address _____

City _____ State ____ Zip _____

Patient/Guardian Phone Number: Home _____ Work_____

SERVICE PROVIDER DEMOGRAPHICS

Area Program/Contracted Provider's Name _____

Billing Address _____

City _____ State ____ Zip _____ Phone _____

For Billing Purposes:

Area Program Medicaid Number

Federal Tax ID Number _____

ASSESSMENT

Symptoms: *Please rate symptoms response to treatment*
(S=Same, B = Better, W= Worse). Those not rated will be assumed absent)

____ Guilt	____ Hyperactivity	___ Obsessions/Compulsions
____ Anxiety	____ Irritability	___ Depressed Mood
____ Panic Attacks	____ Hopelessness	___ Decreased Energy
____ Grief	____ Impulsiveness	___ Elevated Mood
____ Delusions	____ Hallucinations	___ Dissociative States
Paranoia	Worthlessness	Active Substance Abuse
____ Somatic Complaints	____ Emotional/physical/Sexual Trauma Victim	
____ Medical Condition	____ Emotional/physical/Sexual Trauma Perpetrator	
____ Oppositional/Defiant	____ Other _____	

DIAGNOSES

ICD-9 DX _____ (Must have for claims pymt);
Axis I: _____-____; _____-___

Axis II:_____

Axis III: _____

Axis IV: _____

Axis V: Current GAF _____ OR CAFAS _____

Current Risk Assessment: ***(Check all that apply)***

Suicidality: ☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Prior Attempt
Homicidality: ☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Prior Attempt

Crisis Plan in Place: ☐ Yes ☐ No Date of Risk Assessment ___/___/____
Other risk behaviors _____
_____

Medications *(list all psychotropic and other medications)*

Has patient been evaluated for medications? ☐ Yes ☐ No
Does patient follow medication regimen? ☐ Yes ☐ No
Prescribing physician (*Indicate if PCP or Psychiatrist*):
_____

Name of Medication	Current Dosage/Freq.	Start date	Side Effects
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Describe side effects/interventions: _____
_____

Last contact to coordinate treatment: Behavioral ___/___/___ Medical ___/___/____

Treatment Frequency & Duration:

Date first seen ___/_____/_____ Date last seen ____/_____/_____

Projected date of the 27th visit if patient is **under** 21 _____/_____/_____

Projected date of 9th visit if patient is 21 or older _____/_____/_____

Treatment Type	# Visits Requested	Frequency (#vs/wk; mo., etc)	Estimated End Date
☐ individual	_____	_____	_____
☐ group	_____	_____	_____
☐ group	_____	_____	_____
☐ family	_____	_____	_____
☐ _____	_____	_____	_____

Treating Provider's Name: _____ Credentials _____ Phone #: _____ Date: _____